SCHENECTADY COUNTY COORDINATED ENTRY APPLICATION

ARE YOU SEEKING HOUSING SERVICES?	HAVE YOU PREVIOUSLY COMPLETED AN APPLICATION FOR ASSISTANCE THROUGH COORDINATED ENTRY?
❑ No ❑ Yes	❑ No ❑ Yes

IF CLIENT IS NOT SEEKING HOUSING SERVICES, A HOUSING ASSESSMENT DOES NOT NEED TO BE COMPLETED

BEFORE STARTING THIS APPLICATION PLEASE MAKE SURE THE APPLICANT:

1. Meets the HUD definition of homeless.
   Lacks a fixed, regular, and adequate nighttime residence, meaning:
   (i) Has a primary nighttime residence that is a public or private place not meant for human habitation;
   (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs);
   OR
   (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution
2. Spent last night in Schenectady County.
3. Does not have a pending CE application. Check with your CE lead if the applicant is not sure.
4. Is not paying for a motel/hotel. DSS must be paying for the stay at the time of application to meet the above definition.

STAFF MEMBER COMPLETING ASSESSMENT	AGENCY NAME

STAFF MEMBER'S EMAIL	PHONE NUMBER	FAX NUMBER

PRESCREENING INFORMATION

ARE YOU CURRENTLY HOMELESS	ARE YOU AT RISK OF BECOMING HOMELESS
❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused
ADDRESS (Please indicate if this is a ❑ current or ❑ previous address	MAILING ADDRESS (if different than address provided)

HMIS INFORMATION

*INTAKE DATE	*FIRST NAME	*LAST NAME (and Suffix)
/ /		

*NAME DATA QUALITY	ALIAS
❑ Full Name Reported ❑ Partial Name, Street Name or Code Name Reported ❑ *Data Not Collected* ❑ *Client Doesn't Know* ❑ *Client Refused*	

*SOCIAL SECURITY NUMBER	*SSN DATA QUALITY
(enter "9" for any missing numbers in an Approximate or Partial SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___	❑ Full SSN Reported ❑ Approximate or Partial SSN Reported ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

*GENDER (Please select all that apply)

❑Female ❑Male ❑Transgender
❑Questioning ❑A gender that is not singularly 'Female' or 'Male'

❑ *Client Doesn't Know*
❑ *Client Refused*
❑ *Data Not Collected*

*BIRTHDATE	*BIRTHDATE DATA QUALITY
_____/_____/_____	❑ Full DOB Reported ❑ Approximate or Partial DOB Reported ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

*ETHNICITY

❑Hispanic/Latin(a)(o)(x) ❑Non- Hispanic/Latin(a)(o)(x)

❑ *Client Doesn't Know*
❑ *Client Refused*
❑ *Data Not Collected*

*RACE (choose all that apply)

❑American Indian, Native Alaskan, or Indigenous
❑Black, African American, African
❑White
❑Asian or Asian American
❑Native Hawaiian or Pacific Islander

❑ *Client Doesn't Know*
❑ *Client Refused*
❑ *Data Not Collected*

*DO YOU HAVE A **PHONE NUMBER** AT WHICH YOU CAN BE REACHED?

❑ No ❑ Yes (SEE RIGHT)	**IF YES**: PLEASE PROVIDE YOUR PHONE NUMBER **WITH AREA CODE** (____) - _____ - _____

IF NO PHONE: HOW CAN APPLICANT BE CONTACTED (Email, Case Manager, Day Program, Lunch Site)

---NEXT PAGE---

*PRIOR LIVING SITUATION

Based on the client's living situation **the night before project entry**, record responses in one (1) section:
Homeless Situation, Institutional Situation, Transitional/Permanent Situation, OR Unknown (**only** if necessary)

HOMELESS SITUATIONS:

TYPE OF RESIDENCE (THE NIGHT BEFORE PROJECT ENTRY)

- ❑ **Place not meant for human habitation** (vehicle, abandoned building, bus/train/subway station etc)
- ❑ **Emergency shelter**, including **hotel or motel** paid for **with emergency shelter voucher**
- ❑ Safe Haven
- ❑ Interim Housing

*LENGTH OF STAY IN PREVIOUS PLACE

- ❑ 1 night or less
- ❑ 2 to 6 nights
- ❑ 1 week or more, but less than 1 month
- ❑ 1 month or more, but less than 90 days
- ❑ 90 days or more, but less than 1 year
- ❑ 1 year or longer
- ❑ *Client Doesn't Know*
- ❑ *Client Refused*
- ❑ *Data Not Collected*

*APPROXIMATE DATE HOMELESSNESS STARTED:

_____/_____/_____

*REGARDLESS OF WHERE THEY STAYED LAST NIGHT NUMBER OF TIMES ON THE STREETS, IN ES, OR SH IN THE PAST THREE YEARS

❑ 1 ❑ 2 ❑ 3 ❑ 4+

- ❑ *Client Doesn't Know*
- ❑ *Client Refused*
- ❑ *Data Not Collected*

*TOTAL NUMBER OF MONTHS HOMELESS ON THE STREETS, IN ES, OR IN SH IN THE PAST THREE YEARS

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7
❑ 8 ❑ 9 ❑ 10 ❑ 11 ❑ 12 ❑ More than 12

- ❑ *Client Doesn't Know*
- ❑ *Client Refused*
- ❑ *Data Not Collected*

OR

INSTITUTIONAL SITUATIONS:

TYPE OF RESIDENCE (THE NIGHT BEFORE PROJECT ENTRY)

- ❑ **Foster care** home or foster care group home
- ❑ **Hospital** or other residential non-psychiatric medical facility
- ❑ **Jail**, prison or juvenile detention facility
- ❑ **Long-term care facility** or n**ursing** home
- ❑ **Psychiatric hospital** or other psychiatric facility
- ❑ **Substance use treatment** facility or detox center

*LENGTH OF STAY IN PREVIOUS PLACE

- ❑ 1 night or less
- ❑ 2 to 6 nights
- ❑ 1 week or more, but less than 1 month
- ❑ 1 month or more, but less than 90 days
- ❑ 90 days or more, but less than 1 year
- ❑ 1 year or longer
- ❑ *Client Doesn't Know*
- ❑ *Client Refused*
- ❑ *Data Not Collected*

DID THE CLIENT STAY LESS THAN 90 DAYS

❑ No ❑ Yes

IF YES: THE NIGHT BEFORE THAT, DID THEY STAY ON THE STREETS, ES, or SH?

❑ No ❑ Yes

IF YES TO 'ON THE NIGHT BEFORE DID YOU STAY ON THE STREETS, ES OR SH?' PROVIDE DETAILS OF PREVIOUS HOMELESSNESS:

*APPROXIMATE DATE HOMELESSNESS STARTED:

_____/_____/_____

*REGARDLESS OF WHERE THEY STAYED LAST NIGHT NUMBER OF TIMES ON THE STREETS, IN ES, OR SH IN THE PAST THREE YEARS

❑ 1 ❑ 2 ❑ 3 ❑ 4+

- ❑ *Client Doesn't Know*
- ❑ *Client Refused*
- ❑ *Data Not Collected*

*TOTAL NUMBER OF MONTHS HOMELESS ON THE STREETS, IN ES, OR IN SH IN THE PAST THREE YEARS

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7
❑ 8 ❑ 9 ❑ 10 ❑ 11 ❑ 12 ❑ More than 12

- ❑ *Client Doesn't Know*
- ❑ *Client Refused*
- ❑ *Data Not Collected*

OR

TRANSITIONAL AND PERMANENT HOUSING SITUATIONS:

TYPE OF RESIDENCE (THE NIGHT BEFORE PROJECT ENTRY)

- ❑ **Hotel or Motel** paid for **without** emergency shelter voucher
- ❑ Owned by client, **no** ongoing subsidy
- ❑ Owned by client **WITH** ongoing subsidy
- ❑ Permanent housing **(other than RRH)** for formerly homeless persons (PSH, HOPWA)
- ❑ Rental by client, **no** ongoing subsidy
- ❑ Rental by client with GPD TIP subsidy
- ❑ Rental by client with VASH subsidy
- ❑ Rental by client with other housing subsidy **(including RRH)**
- ❑ Residential project or halfway house with no homeless criteria
- ❑ **Staying or in a family** member's room, apartment or house
- ❑ **Staying or in a friend's** room, apartment or house
- ❑ **Transitional housing** for homeless persons (incl. homeless youth)

*LENGTH OF STAY IN PREVIOUS PLACE

- ❑ 1 night or less
- ❑ 2 to 6 nights
- ❑ 1 week or more, but less than 1 month
- ❑ 1 month or more, but less than 90 days
- ❑ 90 days or more, but less than 1 year
- ❑ 1 year or longer
- ❑ *Client Doesn't Know*
- ❑ *Client Refused*
- ❑ *Data Not Collected*

DID YOU STAY LESS THAN 7 DAYS?

❑ No ❑ Yes

IF YES: THE NIGHT BEFORE THAT, DID THEY STAY ON THE STREETS, ES, or SH?

❑ No ❑ Yes

IF YES TO 'ON THE NIGHT BEFORE DID YOU STAY ON THE STREETS, ES OR SH?' PROVIDE DETAILS OF PREVIOUS HOMELESSNESS:

*APPROXIMATE DATE HOMELESSNESS STARTED:

_____/_____/_____

*REGARDLESS OF WHERE THEY STAYED LAST NIGHT NUMBER OF TIMES ON THE STREETS, IN ES, OR SH IN THE PAST THREE YEARS

❑ 1 ❑ 2 ❑ 3 ❑ 4+

- ❑ *Client Doesn't Know*
- ❑ *Client Refused*
- ❑ *Data Not Collected*

*TOTAL NUMBER OF MONTHS HOMELESS ON THE STREETS, IN ES, OR IN SH IN THE PAST THREE YEARS

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7
❑ 8 ❑ 9 ❑ 10 ❑ 11 ❑ 12 ❑ More than 12

- ❑ *Client Doesn't Know*
- ❑ *Client Refused*
- ❑ *Data Not Collected*

OR

UNKNOWN (ONLY IF NECESSARY)

TYPE OF RESIDENCE (THE NIGHT BEFORE PROJECT ENTRY)

❑ *Client doesn't know* ❑ *Client refused* ❑ *Data not collected*

---NEXT PAGE---

*CURRENT LIVING SITUATION

Based on the client's living situation **tonight**, record responses in one (1) section:
Homeless Situation, Institutional Situation, Transitional/Permanent Situation, OR Unknown (**only** if necessary)

HOMELESS SITUATIONS:

TYPE OF RESIDENCE (TONIGHT)

- ❑ **Place not meant for human habitation** (vehicle, abandoned building, bus/train/subway station etc)
- ❑ **Emergency shelter**, including **hotel or motel** paid for **with emergency shelter voucher**
- ❑ Safe Haven
- ❑ Interim Housing

OR

INSTITUTIONAL SITUATIONS:

TYPE OF RESIDENCE (TONIGHT)

- ❑ **Foster care** home or foster care group home
- ❑ **Hospital** or other residential non-psychiatric medical facility
- ❑ **Jail**, prison or juvenile detention facility
- ❑ **Long-term care facility** or n**ursing** home
- ❑ **Psychiatric hospital** or other psychiatric facility
- ❑ **Substance use treatment** facility or detox center

IS CLIENT GOING TO LEAVE WITHIN 14 DAYS?	HAS A SUBSEQUENT RESIDENCE BEEN IDENTIFIED?
❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*

DOES INDIVIDUAL OR FAMILY HAVE RESOURCES OR SUPPORT NETWORKS TO OBTAIN OTHER PERMANENT HOUSING?

❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*

HAS THE CLIENT HAD A LEASE OR OWNERSHIP INTEREST IN A PERMANENT HOUSING UNIT IN THE LAST 60 DAYS?

❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*

HAS THE CLIENT MOVED 2 TIMES OR MORE IN THE LAST 60 DAYS?

❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*

OR

TRANSITIONAL AND PERMANENT HOUSING SITUATIONS:

TYPE OF RESIDENCE (TONIGHT)

- ❑ **Hotel or Motel** paid for **without** emergency shelter voucher
- ❑ Owned by client, **no** ongoing subsidy
- ❑ Owned by client **WITH** ongoing subsidy
- ❑ Permanent housing **(other than RRH)** for formerly homeless persons (PSH, HOPWA)
- ❑ Rental by client, **no** ongoing subsidy
- ❑ Rental by client with VASH subsidy
- ❑ Rental by client with GPD TIP subsidy
- ❑ Rental by client with other housing subsidy (**including RRH**)
- ❑ Residential project or halfway house with no homeless criteria
- ❑ **Staying or in a family** member's room, apartment or house
- ❑ **Staying or in a friend's** room, apartment or house
- ❑ **Transitional housing** for homeless persons (incl. homeless youth)

IS CLIENT GOING TO LEAVE WITHIN 14 DAYS?	HAS A SUBSEQUENT RESIDENCE BEEN IDENTIFIED?
❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*

DOES INDIVIDUAL OR FAMILY HAVE RESOURCES OR SUPPORT NETWORKS TO OBTAIN OTHER PERMANENT HOUSING?

❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*

HAS THE CLIENT HAD A LEASE OR OWNERSHIP INTEREST IN A PERMANENT HOUSING UNIT IN THE LAST 60 DAYS?

❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*

HAS THE CLIENT MOVED 2 TIMES OR MORE IN THE LAST 60 DAYS?

❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*

OR

UNKNOWN (ONLY IF NECESSARY)

❑ *Client doesn't know* ❑ *Client refused* ❑ *Data not collected*

LIVNG SITUATION VERIFIED BY (NAME OF AGENCY)

ACCEPTABLE FORMS OF HOMELESSNESS VERIFICATION

- Written observation by outreach worker; or
- Written referral by another housing or service provider; or
- Certification by individual or head of household stating that (s) he was living on the street or in shelter; (Additional 3rd party verification may be required at a later date)

Individuals exiting an institution – one of the forms of evidence above and:

- Discharge paperwork or written/oral referral, or
- Written record of intake worker's due diligence to obtain above evidence and certification by individual that they exited institution.

WAS HOMELESSNESS VERIFIED	IF YES, HOW WAS HOMELESSNESS VERIFIED – INCLUDE DOCUMENTATION WITH COMPLETED APPLICATION
❑ No ❑ Yes	

---NEXT PAGE---

IF THE APPLICANT DOES NOT HAVE VERIFICATION AT THIS TIME, EXPLAIN STEPS WILL BE TAKEN TO OBTAIN THE VERIFICATION

*INCOME & SOURCES / NON-CASH BENEFITS

***INCOME FROM ANY SOURCE**

❑ No ❑ Yes (SEE BELOW) ❑ *Client Doesn't Know* ❑ Client Refused ❑ *Data Not Collected*

IF YES: CHECK & FILL IN **MONTHLY AMOUNT** FOR ALL THAT APPLY

❑ Earned Income ..... $_____	❑ Unemployment Insurance ..... $_____
❑ SSI ..... $_____	❑ SSDI ..... $_____
❑ VA Service-Connected Disability Compensation ..... $_____	❑ VA Non-Service Connected Disability Pension ..... $_____
❑ Private Disability Insurance ..... $_____	❑ Worker's Compensation ..... $_____
❑ TANF ..... $_____	❑ General Public Assistance ..... $_____
❑ Retirement from SSA ..... $_____	❑ Pension or Retirement from former job ..... $_____
❑ Child Support ..... $_____	❑ Alimony or Other Spousal Support ..... $_____
❑ Other ..... $_____	

***NON-CASH BENEFITS FROM ANY SOURCE**

❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

IF YES: CHECK ALL THAT APPLY

❑ SNAP (Food Stamps) ❑ Special Supplemental Nutrition Program for Women, Infants and Children ❑ Other TANF Funded Srvcs
❑ TANF Child Care Services ❑ TANF Transportation Service

*HEALTH INSURANCE / DISABLING CONDITIONS

***COVERED BY HEALTH INSURANCE**

❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

IF YES: CHECK ALL THAT APPLY

MEDICAID ..... ❑ No ❑ Yes	MEDICARE ..... ❑ No ❑ Yes
State Children's Health Insurance Program ..... ❑ No ❑ Yes	VA Medical Services ..... ❑ No ❑ Yes
Employer provided Health insurance ..... ❑ No ❑ Yes	Health ins. Via COBRA ..... ❑ No ❑ Yes
Private Pay Health Insurance ..... ❑ No ❑ Yes	State Health Ins. Adults ..... ❑ No ❑ Yes
Indian Health Services ..... ❑ No ❑ Yes	

***PHYSICAL DISABILITY**	**IF YES:** EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No ❑ Yes (SEE RIGHT) ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

***DEVELOPMENTAL DISABILITY**

❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

***CHRONIC HEALTH CONDITION**	**IF YES:** EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No ❑ Yes (SEE RIGHT) ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

***HIV/AIDS**

❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

***MENTAL HEALTH DISORDER**	**IF YES**: EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No ❑ Yes (SEE RIGHT) ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

***SUBSTANCE USE DISORDER**			**IF YES**: EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No	❑ Yes, Alcohol (SEE RIGHT) ❑ Yes, Drug (SEE RIGHT) ❑ Yes, Both (SEE RIGHT	❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

ACCEPTABLE FORMS OF DISABILITY VERIFICATION

- Written verification of the disability from a professional licensed by the state to diagnose and treat the disability and his or her certification that the disability is expected to be long-continuing or of indefinite duration and substantially impedes the individual's ability to live independently; or
- Written verification from the Social Security Administration; or
- The receipt of a disability check (e.g., Social Security Disability Insurance check or Veteran Disability Compensation); or
- Intake staff-recorded observation of disability that, no later than 45 days from the application for assistance, is confirmed and accompanied by evidence above

All verification must be current (within one year of the date of application)

WAS DISABILITY VERIFIED	IF YES, HOW WAS DISABILITY VERIFIED – INCLUDE DOCUMENTATION WITH COMPLETED APPLICATION
❑ No ❑ Yes	

IF THE APPLICANT DOES NOT HAVE VERIFICATION AT THIS TIME, EXPLAIN STEPS WILL BE TAKEN TO OBTAIN THE VERIFICATION

---NEXT PAGE---

* DV STATUS

*DOMESTIC ABUSE VICTIM/SURVIVOR			
❑ No ❑ Yes (SEE BELOW)			❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*
IF YES: WHEN EXPERIENCE OCCURRED			**IF YES:** ARE YOU CURRENTLY FLEEING?
❑ Within the past 3 months ❑ 3 to 6 months ago	❑ From 6 to 12 months ago ❑ More than a year ago	❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

IF YES: It is advised to connect the client with the domestic violence hotline at 518-374-3386 if they are not already engaged in services. If the location of the client is not safe or they are fleeing, note his/her name with INITIALS ONLY and location as UNDISCLOSED/SHELTERED. Refer to the P&P for additional instructions if needed.

*NON-HMIS DATA ELEMENTS

EMPLOYMENT STATUS	IF YES: TYPE OF EMPLOYMENT	IF NO: WHY NOT EMPLOYED
❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ Full Time ❑ Part Time ❑ Seasonal	❑ Looking for Work ❑ Unable to Work ❑ Not Looking for Work

CURRENTLY PREGNANT?	IF YES: DUE DATE
❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	_____/_____/_____

*VETERAN STATUS	IF YES: SELECT BRANCH
❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ Army ❑ Air Force ❑ Navy ❑ Marines ❑Coast Guard ❑ Other ❑ *Data Not Collected* ❑ *Client Doesn't Know* ❑ *Client Refused*

DISCHARGE STATUS

❑ Honorable ❑ General Under Honorable Discharge ❑ Under Other than Honorable Conditions ❑ Bad Conduct ❑ Dishonorable ❑Uncharacterized ❑ *Data Not Collected* ❑ *Client Doesn't Know* ❑ *Client Refused*

HOMELESS CAUSE (check only one)

❑ Benefits loss/reduction	❑ Released behavioral health facility	❑ Drug/alcohol abuse
❑ Job income loss/reduction	❑ Illness	❑ Other:_____
❑ Eviction	❑ Injury/ Disability	❑ Don't know
❑ Relocation	❑ Domestic Violence	❑ Refused
❑ Released from prison/jail	❑ Asked to leave shared residence (e.g. living in a home of another due to hardship)	
❑ Released from hospital		

*ZIP CODE OF LAST PERMANENT ADDRESS	ZIP CODE DATA QUALITY
_____ _____ _____ _____ _____	❑ Full or Partial Zip Code Reported ❑ Don't Know ❑ Refused

DATE LEFT LAST PERMANENT ADDRESS	HAVE YOU BEEN CONVICETED OF A FELONY
_____/_____/_____	❑ No ❑ Yes ❑ *Client Refused* ❑ *Data Not Collected*

CURRENTLY ON PROBATION OR PAROLE?	REQUIRED TO REGISTER ADDRESS UNDER SOAR
❑ No ❑ Yes ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Refused* ❑ *Data Not Collected*

HAVE YOU OR ANY MEMBER OF YOUR HOUSEHOLD BEEN INVOLVED WITH ANY PROTECTION AGENCY

❑ No ❑ Yes ❑ *Client Refused* ❑ *Data Not Collected*

IF YES: SELECT AGENCY	IF YES: IS THIS A CURRENT CASE
❑ CPS ❑ APS ❑ Juvenile Justice ❑ Family Court ❑ Foster Care ❑ Other:	❑ No ❑ Yes

IF CPS: Provide Protective Agency Worker's Name and Contact Number	IF CPS, IS A REUNIFICATION PLAN IN PLACE
Name: Contact Number: ( ) -	❑ No ❑ Yes

NOTES: If there is any other information the client wishes to disclose to help with this process/placement, please note it here. (e.g. CL does not want treatment, CL is only available after 4p on Tuesdays, CL med docs are with Agency DCBA, CL does not want to work with Agency ABCD, etc.)

---END---

PROCEED TO VULNERABILITY INDEX

VULNERABILITY INDEX SCORING FOR INDIVIDUALS

Chronic Homelessness (CH) Status (CoC Priority)

1. **Does the client/HOH have a disabling condition?**
   If Y, continue to #2
   If N, client cannot be defined as chronically homeless. Go directly to scoring section
2. **Has the client/HOH been continually homeless for a year or more?**
   If Y, client is defined as CHRONICALLY HOMELESS, enter "C" in box below and go directly to scoring section
   If N, go to #3
3. **Has the client/HOH had at least 4 episodes of homelessness in the last 3 years?**
   If Y, go to #4
   If N, client cannot be defined as chronically homeless, go directly to scoring section
4. **Is the combined total of these periods one year or more?**
   If Y, client is defined and CHRONICALLY HOMELESS, enter a "C" in box below and continue to next section
   If N, client cannot be defined as chronically homeless, go directly to scoring section

Time incarcerated/institutionalized can only count toward this total if it was less than 90 day

	SCORE	SUBTOTAL
If applicant stayed LAST NIGHT in a place not meant for human habitation, shelter paid for by DSS, TH, or Institutional Setting	5	
If applicant acknowledges experiencing domestic violence in the last 30 days	1	
If applicant is 18-24 years of age	1	
If applicant is 60 years of age or older	1	
If applicant has served one day (other than training) in active military, naval, or air service	1	
If applicant is pregnant	1	
If applicant has a documented disability	1	
If applicant has two (2) or more documented disabilities	1	
If applicant indicates they have no income OR only receive DSS assistance	1	
If applicant indicates criminal history, and/or current probation or parole status	1	
If client has had any recent involvement with a Child Protective, Adult Protective, Juvenile Justice, Family Court, or Foster Care Agency	1	
If client has had multiple points of contact (3 or more) with Emergency Responders such as ambulance, or ER visits within the last 90 days	1	
If client has a serious underlying medical condition and may be at higher risk for severe illness from COVID-19 due to the following: chronic lung disease, moderate to severe asthma, severe obesity, diabetes, immunocompromised, chronic kidney disease, and/or liver disease	2	
TOTAL POINTS – If documented CH status, add "C" (i.e., "4C")	18	

VULNERABILITY INDEX SCORING FOR FAMILIES

	SCORE	SUBTOTAL
If HOH stayed LAST NIGHT in a place not meant for human habitation, shelter paid for by DSS, TH, or Institutional Setting	5	
If HOH acknowledges experiencing domestic violence in the last 30 days	1	
If HOH is 18-24 years of age	1	
If HOH is 60 years of age or older	1	
If any HH member has served one day (other than training) in active military, naval, or air service	1	
If any HH member is pregnant	1	
If HOH has a documented disability	1	
If HOH has two (2) or more documented disabilities	1	
If other members of the household (not HOH) have a documented disability	1	
If no one in the household has income OR only receive DSS assistance	1	
If anyone in the household indicates criminal history, and/or current probation or parole status	1	
If HOH has had any recent involvement with a Child Protective, Adult Protective, Juvenile Justice, Family Court, or Foster Care Agency	1	
If HOH has had multiple points of contact (3 or more) with Emergency Responders such as ambulance, or ER visits within the last 90 days	1	
If client has a serious underlying medical condition and may be at higher risk for severe illness from COVID-19 due to the following: chronic lung disease, moderate to severe asthma, severe obesity, diabetes, immunocompromised, chronic kidney disease, and/or liver disease	2	
TOTAL POINTS – If documented CH status, add "C" (i.e., "4C")	19	

CONTINUE ON TO NEXT PAGE IF WORKING WITH A HOUSEHOLD OF TWO OR MORE
IF NOT, SKIP TO CCHMIS INCLUSION DISCLOSURE

Questions below are required for: Any Additional Household Members

FIRST NAME / LAST NAME	GENDER	RELATIONSHIP TO HEAD OF HOUSEHOLD

SOCIAL SECURITY NUMBER	BIRTHDATE
(enter "9" for any missing numbers in an Approximate or Partial SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___	_____/_____/_____

PHYSICAL DISABILITY	**IF YES:** EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No ❑ Yes (SEE RIGHT) ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

DEVELOPMENTAL DISABILITY
❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

CHRONIC HEALTH CONDITION	**IF YES:** EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No ❑ Yes (SEE RIGHT) ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

HIV/AIDS
❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

MENTAL HEALTH DISORDER	**IF YES**: EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No ❑ Yes (SEE RIGHT) ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

SUBSTANCE USE DISORDER	**IF YES**: EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No ❑ Yes, Alcohol (SEE RIGHT) ❑ Yes, Drug (SEE RIGHT) ❑ Yes, Both (SEE RIGHT ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

Questions below are required for: Any Additional Household Members

FIRST NAME / LAST NAME	GENDER	RELATIONSHIP TO HEAD OF HOUSEHOLD

SOCIAL SECURITY NUMBER	BIRTHDATE
(enter "9" for any missing numbers in an Approximate or Partial SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___	_____/_____/_____

PHYSICAL DISABILITY	**IF YES:** EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No ❑ Yes (SEE RIGHT) ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

DEVELOPMENTAL DISABILITY
❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

CHRONIC HEALTH CONDITION	**IF YES:** EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No ❑ Yes (SEE RIGHT) ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

HIV/AIDS
❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

MENTAL HEALTH DISORDER	**IF YES**: EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No ❑ Yes (SEE RIGHT) ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

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❑ No ❑ Yes, Alcohol (SEE RIGHT) ❑ Yes, Drug (SEE RIGHT) ❑ Yes, Both (SEE RIGHT ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

IF THERE ARE MORE THAN TWO ADDITIONAL HOUSEHOLD MEMBERS, CONTINUE ONTO NEXT PAGE.
IF NOT, SKIP TO CCHMIS INCLUSION DISCLOSURE

Questions below are required for: Any Additional Household Members

FIRST NAME / LAST NAME	GENDER	RELATIONSHIP TO HEAD OF HOUSEHOLD

SOCIAL SECURITY NUMBER	BIRTHDATE
(enter "9" for any missing numbers in an Approximate or Partial SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___	_____/_____/_____

PHYSICAL DISABILITY	**IF YES:** EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No ❑ Yes (SEE RIGHT) ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

DEVELOPMENTAL DISABILITY
❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

CHRONIC HEALTH CONDITION	**IF YES:** EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No ❑ Yes (SEE RIGHT) ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

HIV/AIDS
❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

MENTAL HEALTH DISORDER	**IF YES**: EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No ❑ Yes (SEE RIGHT) ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

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Questions below are required for: Any Additional Household Members

FIRST NAME / LAST NAME	GENDER	RELATIONSHIP TO HEAD OF HOUSEHOLD

SOCIAL SECURITY NUMBER	BIRTHDATE
(enter "9" for any missing numbers in an Approximate or Partial SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___	_____/_____/_____

PHYSICAL DISABILITY	**IF YES:** EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No ❑ Yes (SEE RIGHT) ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

DEVELOPMENTAL DISABILITY
❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

CHRONIC HEALTH CONDITION	**IF YES:** EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No ❑ Yes (SEE RIGHT) ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

HIV/AIDS
❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

MENTAL HEALTH DISORDER	**IF YES**: EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No ❑ Yes (SEE RIGHT) ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

SUBSTANCE USE DISORDER	**IF YES**: EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?
❑ No ❑ Yes, Alcohol (SEE RIGHT) ❑ Yes, Drug (SEE RIGHT) ❑ Yes, Both (SEE RIGHT ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

IF THERE ARE MORE THAN FOUR ADDITIONAL HOUSEHOLD MEMBERS, PLEASE PHOTOCOPY THIS PAGE TO COMPLETE OR REACH OUT TO CARES TEAM

---END---

PROCEED TO CCHMIS COORDINATED ENTRY CLIENT INCLUSION DISCLOSURE

CCHMIS COORDINATED ENTRY CLIENT INCLUSION DISCLOSURE

PURPOSE: To inform clients of HMIS data entry and for clients to authorize or modify data sharing preferences within the HMIS for the project listed below:

AGENCY/PROVIDER: **SCHENECTADY COUNTY COORDINATED ENTRY**

INSTRUCTIONS: This form must be completed for every independent adult (18 years of age and over) and every unaccompanied minor PRIOR to data collection and entry into the HMIS at all CCHMIS-participating providers. This form also covers any household members under the client's guardianship, which includes all minors (persons under 18 years of age) and any incapacitated/disabled adults. The client is to be given pages 1 and 2 after completion.

HMIS PRIVACY NOTICE

This Notice applies to all CCHMIS-Participating Providers and addresses how information about clients may be used and disclosed at Providers as well as client rights over their information. This Notice may be amended at any time, and amendments may affect information obtained before the date of the amendment.

A. HMIS DATA COLLECTION & PURPOSE

A Homeless Management Information System (HMIS) is a local information technology system used to collect data on the housing and services provided to homeless individuals and families and persons at risk of homelessness. Providers participating in an HMIS are required to collect universal data elements from all clients, including Personally Identifying Information, demographic characteristics, and residential history. This information is critical for providers and communities to better understand the extent and nature of homelessness at a local level, evaluate program effectiveness, and improve future housing and service provision. Some providers are also required by their funders to obtain certain additional information to assess services, to determine eligibility, and to monitor outcomes. Most federally-funded homeless service providers are required to participate and record the clients they serve in an HMIS.

This agency is an HMIS-participating homeless service provider ("CCHMIS Provider"), meaning we collect and enter information about the persons we serve in the private and secure CARES Regional HMIS (CCHMIS) database, the local HMIS for this community. There are firm policies and procedures in place to protect against unauthorized disclosure of any personal information collected, and this information is critical to obtain an accurate picture of the homeless population we serve and for this agency to continue to offer you the service(s) you are accessing today. We only collect information deemed appropriate and necessary for program operation or information that is required by law or by the organizations that fund this program. We do not need your consent to enter a record of your visit into the CCHMIS, but you may refuse to have your personal identifying information within this record and still be eligible to receive services.

If you have any concerns or questions about the information provided above, please speak to an intake worker.

B. PERMITTED DATA USES AND DISCLOSURES

The CCHMIS is designed to protect the confidentiality of personal information while allowing for reasonable, responsible, and limited uses and disclosures of data, including Personally Identifying Information (PII is any information that can be used to identify a particular individual, including a client's name, Social Security Number, and Date of Birth). Once collected, we (as a CCHMIS Provider) have obligations about how these data may be used and disclosed (**uses** are internal activities for which providers interact with client PII; **disclosures** occur when providers share PII with an external entity). CCHMIS **Providers are limited to the following circumstances for the use and disclosure of HMIS PII:**

HUD required:

(1) Client access to their information; and
(2) Disclosures for oversight of compliance with HMIS privacy and security standards.

HUD permitted:

(3) To provide or coordinate services to an individual;
(4) For functions related to payment or reimbursement for services;
(5) To carry out administrative functions, including but not limited to legal, audit, personnel, oversight and management functions;
(6) For creating de-identified reporting from PII;
(7) Uses and disclosures required by law;
(8) Uses and disclosures to avert a serious threat to health or safety;
(9) Uses and disclosures about victims of abuse, neglect or domestic violence;
(10) Uses and disclosures for research purposes; and
(11) Uses and disclosures for law enforcement purposes.

A client must provide prior written consent for any other use or disclosure of HMIS PII.

CCHMIS Providers must also ensure that **any use or disclosure does not violate other applicable local, state, or federal laws**. Therefore, some CCHMIS Providers **may have more restrictive privacy policies**, often dependent upon funding source or the nature of a projects. Specific, per-project information regarding data use and disclosure can be obtained upon request.

C. CLIENT CONTROL OVER DATA

The CCHMIS recognizes every independent legal adult (person over 17 years of age) as the owner of all information about themselves, and any parent, legal guardian, or legal power of attorney as the designated owner of all information about any household members under their guardianship (all minors and any incapacitated/disabled adults).

By seeking assistance from this CCHMIS Provider and consenting to your personal information being entered into a record within the CCHMIS, you transfer governance responsibility over your CCHMIS record to us, and we are responsible for handling your record in accordance with CCHMIS privacy policies and any applicable federal, state, or local requirements. You retain ownership of your information within your CCHMIS record, and as owner **you have the following rights, in general:**

- Refusal: to refuse to answer a question you do not feel comfortable with and not have it recorded within the CCHMIS;
- Access/Correction: to request and view a copy of your project information record within the CCHMIS from your provider, including those who have accessed and/or edited your record, and to request corrections to that record;
- Grievance: to ask questions of or submit grievances to your provider regarding privacy and security policies and practices;
- Anonymized Record: to request that your provider anonymize your personal data record within the CCHMIS; and
- Optional Data Sharing: to choose if your information is shared outside of the CCHMIS with researchers and other providers, and to make this decision at each project you receive services from. (Please note that if you decide NOT to data share, it does not prohibit the project from entering your data into the CCHMIS – it prohibits the sharing of your data as outlined on the consent form).

CCHMIS Providers reserve the following exceptions to the above: (1) Provider Right to Deny Review: if information is compiled in reasonable anticipation of litigation or comparable proceedings; if information about another individual other than the participating provider staff would be disclosed; if information was obtained under a promise of confidentiality other than a promise from this provider and disclosure would reveal the sources of the information; or if the disclosure of information would be reasonably likely to endanger the physical safety of any individual; and (2) Provider Right to Deny Access/Correction: in response to repeated or harassing requests.

D. RESPONSIBILITY TO PROTECT DATA

CARES of NY, Inc. (CARES) is the System Administrator of the CCHMIS. The CCHMIS uses Foothold Technology's AWARDS software application and database, which is maintained in compliance with all federal standards set forth in the Health Insurance Portability and Accountability Act (HIPAA) and its subsequent legislation – the standards required to protect medical records – as well as U.S. Department of Housing and Urban Development HMIS standards.

The CARES CCHMIS staff take the protection of client confidentiality and privacy seriously. **The following security measures, among others, are in place to ensure that your information is protected:**

- System Security: HMIS data is encrypted and securely transmitted from Providers to the HMIS database, extensive procedures are in place to prevent unauthorized access, and the entire HMIS system and database is protected at the highest level of security for health data;
- Access: Only CARES CCHMIS staff and staff at providers may receive authorization to access the CCHMIS, and authorization requires comprehensive initial training and annual privacy and security training thereafter;
- Confidentiality Agreements: Every CCHMIS Provider and every person authorized to read or enter information into the CCHMIS signs an agreement every year that includes: (1) commitments to maintain the confidentiality of all CCHMIS information; (2) commitments to comply with all security measures in compliance with federal HMIS requirements and any applicable federal, state, or local laws; and (3) penalties for violation of the agreement;
- Monitoring: Annual monitoring is conducted for CCHMIS providers to ensure compliance with privacy and security policies; and
- Reporting: Published CCHMIS reports are comprised of aggregate data only, and never contain any client-level or identifying (PII) data.

IMPORTANT INFORMATION FOR ALL CLIENTS – PLEASE READ

If you do not understand any of the information within this form, you may ask your intake worker for further explanation or an alternate format.

You may **keep the first 2 pages** of this form (containing the HMIS Privacy Notice) for your records.

You may request a copy of any participating provider or CCHMIS policies from your intake worker. Further information regarding CCHMIS privacy and security is also available in the CCHMIS Policies and Procedures (accessible online at www.caresny.org/).

You may contact your participating provider regarding any of your rights as listed above, including if you feel that any of these rights have been violated. If your provider's response does not satisfy you, you may then contact the CCHMIS directly at hmis@caresny.org or (518) 489-4130.

E. ACKNOWLEDGEMENT OF INCLUSION

No client consent is required to enter client data from provider forms into the CCHMIS, including personally identifying information. All Protected Identifying Information (PII) entered into the HMIS for the purpose of Coordinated Entry may be shared with other participating providers through the HMIS to better serve your needs and streamline the intake process. Additional sharing of your PII will not happen without agreeing through the consent below.

To show you are aware of this, we ask you to initial below.

**_____ Please initial to indicate that you have read (or been read) and understand the above information.

Please indicate method by which acknowledgement was received.

□ Phone

□ In Person

IMPORTANT - CLIENT IS TO BE GIVEN A COPY OF THE CCHMIS COORDINATED ENTRY CLIENT INCLUSION DISCLOSURE

---NEXT PAGE---

REFERRAL FOR SERVICES Please indicate the agencies/programs this referral will be sent to:				
Agency	**Program**	**Primary Diagnosis**	**Description**	**Contact**
INVIDVIDUALS ONLY				
Bethesda House	☐ Liberty Consolidated	Chronic Homelessness	PSH, Rent 40% of income, 12 beds (834 State St)	Danny Payne (dpayne) and Crystal Thatcher (cthatcher)
	☐ Pathways to the Future	Chronic Homelessness	PSH, Rent 40% of income, 4 beds (834 State St)	
	☐ The Beacon	Chronic Homelessness	Scattered sties, Rent, 30% of income, 8 units	
YMCA	☐ Shelter Plus Care	Disabling Condition, Male only	SRO, Rent 30% of income or grants available for no income (845 Commons)	Ed Kowalczyk (ekowalczyk)
Mohawk Opportunities	☐ Permanent and Supported Housing	Mental Illness	PSH, Rent 30% of income, scattered sites	Bryan Gentile (BGentile)
	☐ Permanent Housing for Chronically Homeless	Chronic Homelessness w Mental Illness	PSH, Rent 30% of income, scattered sites	
YWCA	☐ Rosa's House	Disabling Condition, Female only	Supportive Housing, Rent is 30% of income, scattered sites	Tamara Flanders (tflanders)
Alliance for Positive Health		HIV+	One-time, short-term or potentially ongoing rental subsidy until Section 8 opening, rent is 30% of income, client locates apartment, and engage with housing retention services throughout enrollment	Randy Viele (rviele)
INDIVIDUALS AND FAMILIES				
New Choices	☐ Shelter Plus Care	Drug or Alcohol Addiction	Ongoing rental subsidy, Rent is 30% of income, client locates apartment	Tricia Le (tle)
SCAP	☐ Rapid Rehousing	None but must be able to increase income	Temporary rental subsidy, staff assist with housing search, case management required	Elizabeth Mosier (emosier)
	☐ SMHA Shelter Plus Care	Disabling Condition	Ongoing rental subsidy, rent is 30% of income, client locates apartment, MUST engage with treatment/case management	
	☐ Hillside	None	Fixed site, rent is based on income	
VCHC	☐ Rapid Rehousing	Veteran	Short-term financial assistance for permanent housing w/short term case management.	Johanna Guilfoyle (jguilfoyle)
Soldier On	☐ Rapid Rehousing	Veteran	Temporary rental subsidy or financial assistance to assist with placement in permanent housing	Katrina Middleton (kmiddleton)
FAMILIES ONLY				
SCAP	☐ Permanent Housing	Disabling Condition	PH, 27 units, 81 beds	Elizabeth Mosier (emosier)

APPLICATION SUBMISSION INSTRUCTIONS

To successfully submit this application:

Please scan and email the required documents (listed below) and any relevant supporting documents *through the AWARDS messaging module* to the **Housing Agencies** you indicated in the "REFERRAL FOR SERVICES" section above and **CC: kmcphail in AWARDS**

Faxed, hand-delivered, or applications sent via regular email will not be eligible for review.

Required Coordinated Entry Documents:

- ❑ Completed Coordinated Entry Application
- ❑ Proof of Homelessness
- ❑ Proof of HUD-defined Disabling Condition